

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
Quality Assurance Division - Licensure Bureau

2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953

APPLICATION and RE-APPLICATION FOR AN ADULT FOSTER HOME

Name of Facility: _____

(Last Name) (Owner's First Name) (Middle Name)

(Last Name) (Co-Owner's First Name) (Middle Name)

Facility Street Address: _____

Mailing Address: _____

Facility Telephone: _____ **Other Phone:** _____

Fax (if available): _____

► **Total Number of Adults you wish to serve**
(maximum number allowed for adult foster care is 4): _____

► **Will you be serving:** Males only ☐ Females only ☐ Both ☐

Application for Licensure is being made to serve the following population/ s (Please check all that apply):

☐ **Persons with Developmental Disabilities**
Are you currently contracting for services or do you intend to contract for
services with the Developmental Disabilities Division? Yes ☐ **No** ☐

☐ **Elderly**

☐ **Persons with Mental Illness**
Are you currently contracting for services or do you intend to contract for
services with an area Mental Health Center? Yes ☐ **No** ☐

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<i>Names of Adult Members of Household** and Caregivers / Employees (**not including residents)</i>	<i>Date of Birth</i>	<i>Completed "Personal Statement of Health" Attached?</i>	<i>TB test results attached?</i>	<i>Release of Information form (ROI) attached?</i>
<i>Names of children under age 18 residing in household</i>				

Applicant, please also attach the following items:

- ☐ ***Floor plan indicating square footage of rooms***
- ☐ ***Fire Safety Checklist***
- ☐ ***Grievance Policy***
- ☐ ***Resident Payment Refunds Policy***
- ☐ ***Written Placement Agreement***
- ☐ ***Accident/sudden illness report form***

ENCLOSE A CHECK, MONEY ORDER OR DRAFT MADE PAYABLE TO THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES FOR THE LICENSE FEE OF \$20.00. THIS FEE WILL BE DEPOSITED IN THE STATE TREASURY AND IS NONREFUNDABLE.

I certify that all information I have furnished to the Department of Public Health and Human Services is true and correct.

(Signature of Husband or Owner)

(Date)

(Signature of Wife or Co-Owner)

(Date)